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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LISA KARLYN BAKER** **5000 Red Creek Springs Road, Space 186** **Pueblo, CO 81005** **Registered Nurse License No. 605399** Respondent.	Case No. 2013-354 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 27, 2002, the Board issued Registered Nurse License Number 605399 to Lisa Karlyn Baker ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2013, unless renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

7. Code section 125.3 states, in pertinent part:

> (a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.
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> . . . .
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> (i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement . . .

CAUSE FOR DISCIPLINE

(Gross Negligence)

8. At all times relevant to the charges brought herein, Respondent was employed as a registered nurse at Barton Skilled Nursing Facility ("BSNF") located in South Lake Tahoe, California, and was assigned as the charge nurse for the night shift.

Patient C

9. On or about December 16, 2010, Respondent was caring for an alert 79 year old female patient, Resident C, who was bedridden. The resident was experiencing severe pain in her right shoulder and arm, so a call was placed to the physician. A telephone order was obtained from the physician for "MS Contin 15 mg po (by mouth) q (every) AM PRN (as needed) NOTE; PRN *in AM only*". Respondent was told by the nurse on the previous shift that she should give the medication to the resident as soon as it arrived. Rather than checking the actual physician's order, Respondent relied on the verbal report from the previous nurse and administered the medication to the resident at 9:00 p.m.

Patients A and B

10. On and between December 22, 2010, and December 23, 2010 (from approximately 6:43 p.m. to 7:42 a.m.), Respondent worked a 12 hour shift caring for various residents, including Resident A, a 93 year old female patient with end stage dementia.

11. On or about December 23, 2010, following Respondent's shift, the resident was found obtunded with pin-point pupils and non-responsive to painful stimuli with an oxygen saturation rate of 40 percent. The physician was notified of the resident's condition and ordered Narcan to be administered by IV to attempt to rouse the resident. Various doses of Narcan were administered to the resident, to no avail. The staff was hesitant to transfer the resident to the hospital for treatment as she was classified as a "do not transfer to the hospital" and "do not resuscitate" per the wishes of the resident's daughter. The daughter was notified of her mother's condition and reversed both orders, agreeing to have her mother transferred to Barton Memorial Hospital emergency room for evaluation. While in the emergency room, the resident was given IV Narcan at a much higher dose, was intubated, and was given a urine test. The test results

showed that the resident had opiates in her system; however, the resident did not have a physician's order for opiates at BSNF or at Barton Memorial Hospital. The patient was then admitted to the ICU. Later, the staff at BSNF discovered that Resident A's 89 year old roommate, Resident B, had a physician's order for MS Contin 30 mg for pain. Respondent had documented on Resident B's medication sheet that she had administered MS Contin 30 mg to Resident B at 0600 hours on December 23, 2010. The staff determined that Respondent had given Resident A the MS Contin instead.

12. On or about June 21, 2011, during an interview with the Division of Investigation, Department of Consumer Affairs, Respondent stated that she had traded shifts with another nurse (referring to the shift of December 22, 2010, to December 23, 2010) and was not familiar with the residents in that area of BSNF. Respondent also stated that the "only way" to verify the identification of the residents was by using a picture of the resident, which was contained within the resident's chart. Respondent indicated that it was sometimes difficult to match up the correct resident during the night shift, but did not state whether she actually checked Resident A's photo. Respondent admitted that she relied on a CNA (certified nursing assistant) to identify Resident A during the medication pass.

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in or about December 2010, Respondent committed acts constituting gross negligence in her care of Residents A, B, and C as defined in Regulation 1442, as follows: Respondent failed to comply with the "five rights of medication administration" by administering MS Contin 15 mg to Resident C at the "wrong time", as set forth in paragraph 9 above, and administering MS Contin 30 mg to the "wrong patient", Resident A, as set forth in paragraphs 10 and 11 above. Further, as a consequence of her medication error involving Resident A, Respondent failed to administer the MS Contin 30 mg to Resident B as ordered by the resident's physician.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 605399, issued to Lisa Karlyn Baker;

2. Ordering Lisa Karlyn Baker to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: November 1, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2011102522